A COMMUNICATIVE JOURNEY FROM DYSFUNCTIONAL-TO-FUNCTIONAL IN A THERAPEUTIC COMMUNITY FOR SUBSTANCE ABUSE

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A

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ABSTRACT

The research question for this study explores change in the lived experience of the substance abuser whose life is moving from dysfunctional-to-functional and investigates how communication grounds this change in human interaction. Communication appears in experience as one changes from addictive substance dysfunctionality to a balanced functionality. The communicative processes, in the setting of a therapeutic community, are constructive to such transitions.

The methodology for answering this question of how suggests addressing the lived experience of transition. Narrative analysis of the eight open-ended interviews produced three emergent themes. Those emergent themes are (1) *isolation,* (2) *self-disclosure*, and (3) *connectedness*. The process of communicative interaction is a vital step demonstrated in all three emergent themes within the context of a therapeutic community.

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INTRODUCTION

Personal interest in the ways that the co-constructive communication process engenders healing instigated this study. I wondered how communication functions to extricate addictive individuals from their social dilemma. Transforming an individual's self–perception from the negative of addiction to the positive of a socially functional identity is clearly beneficial to the individual, that individual's social network, and to society.

According to Milton Erickson, MD, in his foreword to Watzlawick, Weakland, & Fisch's (1974) book, change "is of vital importance in any understanding of human behavior for the self and others" (p. ix). Watzlawick, et al. (1974) propose two kinds of change. Metaphorically, the person in the nightmare of addiction, as a normal pattern, uses "first-order change," i.e., they "run, hide, fight, scream, jump off a cliff, etc." in their nightmare, but they stay in the nightmare or the same system. As long as he or she remains in the nightmare they are in isolation. To change systems is called "second-order change" (Watzlawick, et al., p. 10). The substance abuser cannot socially function in the nightmare and needs to change to a different state altogether—a second-order change, or as the metaphor suggests, entering into second-order change he or she needs to wake from the nightmare.

This study emerges from the question: how does positive, therapeutic communication affect change for one immersed in substance abuse on his or her journey from the dysfunctional-to-functional process of living. To frame this

inquiry, I considered several different bases of research: Objectivism, Constructionism, and Subjectivism. According to Crotty (1998) these three epistemologies are foundational to social research. Because this study is driven by the research question – "how is this possible?" – it is firmly in the epistemological genre of Constructionism.

CHAPTER 1: LITERATURE REVIEW

Afraid to be known, I can know neither myself nor any other; I will be alone.
--Richard Beauvias, 1965

Social Constructionism and Language

The purpose here is to demonstrate a framework or epistemological view of social constructionism. The use of language and self-identity is investigated as part of the social construction process. Therapeutic community and forms of treatment are the last issues attended.

The Social Construction of Reality (Berger & Luckman, 1967) has become a seminal work in the field of Communication for its treatise on the construction of reality. Mills (1940) posits language as creating and sustaining social order. Later, the psychologist Harré (1989a, 1989b, 1983) recognizes the self as being both "social" and "individual" as determined by language. Human communication as a social concept is important to Social Constructionist theory. Shotter explicates (1991, 1989, 1984) that social construction is also the basis for "social accountability and the social construction of you," (1989, p. 133) and he extends the role that linguistics plays in social construction of words, symbols, and behaviors as they create a social world through communicative interaction. Shared meaning allows for the construction of self in interaction with "other," and provides a basis for society through these words, symbols, and behaviors (Leeds-Hurwitz, 1995). Therefore, one constructs meaning through one's own perceptions of socially shared goals.

Sociologists Berger & Luckman (1967) fostered the position:

> When the generalized other has been crystallized in consciousness, a symmetrical relationship is established between objective and subjective reality. What is real "outside" corresponds to what is real "within." Objective reality can readily be "translated" into subjective reality, and vice versa. Language, of course, is the principle vehicle of this ongoing translating process in both directions. (p. 133)

In co-constructing a reality, one jointly creates that experience through interaction with another. Co-construction is defined by Jacoby & Ochs (1995) as "the joint creation of a form, interpretation, stance, action, activity, identity, institution, skill, ideology, emotion, or other culturally meaningful reality" (p. 171).

Burr (1995) calls Social Constructionism a labeling term, indicating that there is no "single description" that would cover all "social constructionist" perspectives (pp. 1-2). However, Gergen (1985) offers key assumptions for the Social Constructionist viewpoint. They include a critical stance toward taken-for-granted knowledge, historical and cultural specificity, knowledge as sustained by social processes, and the position that knowledge and social action go together. These assumptions help to differentiate Constructionism from other epistemological worldviews.

Foucault (1986, 1981) explores the power of language in the creation of self. We are born into a language and culture, and that language and culture guides our belief system about a self to which we ascribe existence. Sociological influences in American science are grounded in the ideas of Mead's (1934) book,

Mind, Self, and Society, followed by Berger & Luckman's 1976 work, The Social Construction of Reality. The language and culture into which one is born constructs one's assumptions. Burr (1995) explains that we live out our assumptions in our daily interactions with others, that cultural rules are not inside the self, but rather, "people learn their culture's rules as they grow up and gradually become adept at their use" (p .129). Individuation of culture, in this light, appears as the multiplicity of selves we create in the contexts of our social embeddedness (Gergen, 1999).

Harré and Gillett (1994) address the understanding of ourselves in the social world through the concept of the discursive self. As Harré (1989b) demonstrates, our language interaction structures selfhood and we experience the world as a result of this structuring. Because Western thinking is rooted in a cause and effect concept, Harré admonishes us, when listening to reasons given for behavior, that we should hear those reasons as a perceived description of a cause-effect relationship. He indicates that when using cause-effect terms we are absolving ourselves from responsibility by creating a self who holds itself blameless for its own behavior. Another point Harré & Gillett (1994) make is the emphasis of choice. The reflexive process of introspection is a way we look into why we believe what we believe (in other words, make the invisible visible), and know where we are operating and why.

Social realities are embedded in the Human Communication discipline's mantra that human communication is created, maintained, and transformed in

human interaction. Gergen (1991) indicates "words are not mirror like reflections of reality, but experiences of group convention" (p. 119). These conventions are seen in social approaches as the creation of social meaning and social reality, often through both the process of communication and its products. Another similarity among social approaches is the presence of the "related concepts of social role and cultural identity" as "parallel topics of study" (Leeds-Hurwitz, 1995, p. 8). In using social approaches one accepts the holistic view, including subject, object, and researcher as part of the whole, thus indicating "reflexivity implies accepting a multiplicity of meanings in events, and of participants' viewpoints" (Leeds-Hurwitz, 1995, p. 10).

Identity and the Discursive Self

In North American society, the individual is best perceived as a postmodern self; that is, a multiplicity of selves (Gergen, 1991). As Gergen claims, we are all "saturated" with selves, a "multiplicity of self-investments" or a "plethora of selves" which he refers to as "multiphrenia" (pp. 73-74). Gergen suggests technology has made it possible to communicate not only in interpersonal relationships, families, and communities, but also through global technology. To address the resulting multiplicity of roles, the self is now, at once, a multiplicity of selves. This study specifically addresses the transformation of the addictive self as change takes place through interaction within a therapeutic community in the search for a functional process of living; a functional self.

Gergen's (1991) The Saturated Self: Dilemmas of Identity in Contemporary Life thoroughly discusses the interactive construction of life for individuals in society. He posits there is a "state of social saturation" (p. 3). This kind of social saturation exists as a multiplicity of selves and is precipitated by modern technology that allows individuals to expand their world through the telephone, electronic devices such as radio and computers, and transportation modes such as automobiles and airplanes. Social Constructionism also provides a foundation for a discussion of identity. How does the self emerge as an individual? How does society and culture co-constitute that self? According to Deetz (1982), communicative interaction is the field where "reality construction, confirmation, and transformation takes place" (p.2).

Harré & Gillett (1994) offer a discursive account of the self by first showing the dual context of human sciences; the two worlds humans live in being the physical world and the "world of signs and symbols" (p. 99). Using an approach of symbolic interaction, they show how discursive skills are accomplished. Each culture or society organizes its own conventions for the use of signs and symbols. A sense of self or selfhood is associated with our personal identity through two reflections, the identity of the body and the personal identity. Identity is a fluid and fluctuating self-concept and our "cluster of beliefs about [ourselves] . . . has been called the self-concept" (Harré & Gillett, 1994, p. 103).

Discussions of self as "not discovered," but rather "presupposed" were made by Harré & Gillett who view the "sense of self" as unique in regard to our

"discursive presentation" (1994, p. 103). One's sense of self is located in time and space as an unfolding, and there is a social place where one perceives self. (Harré & Gillett, 1994, pp. 103-104). When one researches selfhood as a discursive product, it is subject to and arrived at by indexical formulation through pronouns. Using this understanding opens the idea of more than one self per body and shows the constitutive power of pronouns in the creation of self. Indexical expressions generate a sense of self as a process, an experience, such as he, she, mother, divorced, drug addict, alcoholic, unemployable, etc. (Harré & Gillett, 1994, pp. 104-111).

Sarup (1996) explores two models of identity. The "traditional" has a fixed, unified identity, such as gender, class, and race. The second model is a process and is constructed along sociological and psychological factors. He states that "identities, our own and those of others, are fragmented, full of contradictions, and ambiguities" (p. 14). In other words, how does one see oneself, and how do others see him or her, and what is the influence of contexted interaction?

The dynamics of working out our inter-relationships are taken for granted. In the storied recounting we do in our everyday lives of the events we deem important we locate the narrative, segmenting it from process by endowing it with a beginning, middle, and end, i.e., we "story" our lived experiences in on-going narrative (Josselson & Lieblich, 1993, 1995). McLeod (1997) hypothesizes that "as a way of knowing, narrative implies a relational world . . . a story exists in a

space between teller and audience" (p. 38). By using the play, Oedipus, and an autobiographical history from In Search of a Past (Fraser, 1984), Sarup (1996) applies the method of narrative analysis to show how one speaks about self. Discourse and content are the two parts of the story that are addressed. He explicates what as narrative and how as the discourse. Each time the story is told, one rearranges the plot, but the kernel is the same and "advances the plot" (Sarup, 1996. p. 17). Thus one's life-story is interpreted each time it is told to self or other, and becomes the reflexive life-story of one's process into identity. Mead (1962) noted that reflexivity is ". . . the turning-back of experience of the individual upon himself [sic] . . ." (p. 134). Reflexivity is the introspective loop that ponders where the addictive self has been, where he or she is, and where he or she is going. Steier (1995) refers to this transformation of the introspective loop, as "a relational reframing, strange loops into charmed loops" (p. 68).

Fraser's (1984) In Search of a Past demonstrates that identity is both individual and collective. Narration assumes communicative interaction. Communication is a process, so "identity is not an object which stands by itself" but changes continually (Sarup, 1996, p. 16). Thus, reality is constituted in communication.

Therapeutic Community

After World War II Therapeutic Communities began to appear in the psychiatric environment and were pioneered in England by Maxwell Jones (DeLeon & Ziegenfus, 1986). Jones's (1953) aim was to replace the "traditional

hierarchy system in hospitals with open communication . . ." involving information sharing, consensus decision, and shared problem-solving among "all patients and staff" (p. 6).

The concept of therapeutic community has been around for centuries but Tom Main coined the term "therapeutic community" in The Hospital as a Therapeutic Institution in 1946. Main (1946) wrote about the first failed attempt by Doctors Bion and Rickman at a military hospital in England that delegated responsibility to patients in 1941-1942. The Northfield Experiment by Bion & Rickman was an attempt to utilize dialogue, language, and education in a context of community care (Tucker, 2000). The concept of making the war veteran responsible for his recovery was radically different from the more traditional psychoanalytic process where physician and staff take responsibility and do everything for the patient in the health context. Psychoanalysts in Britain attempted to use the concept of therapeutic communities for "their framework to understand and work with social systems" (DeLeon & Ziegenfuss, 1986, p. 46).

In the 1960s, self-help alternatives to conventional addiction treatments appeared. The first therapeutic communities were participant developed. DeLeon & Ziegenfuss (1986) further say that even though the first therapeutic communities can be traced to Alcoholics Anonymous (AA) and Synanon, therapeutic community is an ancient concept "existing in all forms of communal support and healing" (pp. 6-7). Although the term therapeutic community was first coined in the Twentieth Century, the concept is much older.

During the 1960s, the traditional addict was a narcotic abuser. In the 1990s, the trends changed and the therapeutic community modality has been adapted to the changing patterns in our society including differing lifestyles, addiction severity, and socioeconomic and ethnic diversity. Statistics show that clients are racially mixed, seventy-five percent are male, and fifty percent are in their mid-to-late twenties. About twenty-five percent (this is increasing) are under twenty-one years of age. Over half of therapeutic community admissions come from dysfunctional families in which divorce is a factor. A staggering seventy-five to eighty-five percent have been arrested for criminal activities (DeLeon & Ziegenfuss, 1986, pp. 6-7). In the United States research has traditionally focused on statistics, eventually reducing most things under inspection to hard data, including individuals. How this data transforms into treatment of individuals as human beings is vital to humanity. Do we stay in the data, always crunching statistics, or do we study the human beings in their "school of living" (O'Brien & Henican, 1993)?

Historically, severe addiction was found more among lower socioeconomic individuals (O'Brian & Henican, 1993). Today, however, the phenomenon is found at all levels of society, among people in all walks of life, and of all ages, according to Therapeutic Communities of America (TCA, 1999), as self-described ". . . active and multi-faceted group of treatment programs" (p. 1). These variations range widely in physical settings, usage of medication, and the variety of drugs available.

Forms of Treatment

Various applications of the therapeutic community principles are Group Therapy/Process, Ex-Addicts as Co-Therapists/Counselors, Psychodrama, and Alcoholics Anonymous. When the therapist has lived the experience, he or she cannot be conned by the residents of the therapeutic community. The idea of using the ex-patient in treating substance abusers has a long history. According to DeLeon & Ziegenfuss (1986), Moreno developed many dimensions of group therapy around 1910, as well as psychodrama (p. 48). Moreno also developed the concept of the Family Systems Treatment, which is a Systems Theory application to a family interactional system. The idea that health is much too serious a matter to be left entirely to the established medical system of physicians and psychiatrists was purported by George Clemenceau, Premier of France during World War I. A familiar refrain heard in therapeutic communities is that "only you can do it, but you cannot do it alone" (O'Brien & Henican, 1993). Investing-in-your-own-recovery is the therapeutic approach.

A fuller account of the therapeutic community perspective can be found in other social science research (Campling & Haigh, 1999; DeLeon, 1997; DeLeon, 1984a, 1984b; DeLeon & Rosenthal, 1979; Harrison, 2000; Tucker, 2000; Yablonsky, 1989). They address therapeutic communities from the psychological idiom perspective and evolve directly from the experiences of recovering participants in therapeutic communities.

Considering interactive communication is important in order to discover why substance abusers eventually seek treatment. O'Brien & Henican (1993), when describing their therapeutic community, Daytop, say that very few of the over 75,000 adults and teenagers who walk through the doors do so voluntarily. Rather, they are encouraged or brought by family and friends, or mandated by law enforcement and the court (p. 80). Recovery from addiction is difficult and demanding work and cannot be forced on someone; a balance between free participation and coercion must be maintained, according to O'Brien & Henican (1993). Addicts have to be convinced that the Therapeutic Community is the only choice left.

Summary

The co-construction of reality in human interaction begins with Constructionism as an epistemological way of viewing the world. Our assumptions and interpretations affect the multiplicity of selves as one interacts with others. One's self-identity, as he or she travels the road to a functional self, is an intricate part of the communicative process of living.

The reconnection of self and roles in interaction are associated with events. These events are built into expectations in stages of redevelopment through interaction. The research question guiding the data gathering for this study is: how does the communicative interaction process work and how does it provide for the construction of self as a functional, contributing member of society when coming from a substance abuse lifestyle? Deetz (1984) suggests

communicative interaction is where “reality construction, confirmation, and transformation” take place (p. 2).

CHAPTER 2: METHODOLOGY

I am interested in the way in which the subject constitutes himself [sic] in an active fashion, by the practices of self . . . [These practices] are patterns that he [sic] finds in his [sic] culture and which are proposed, suggested, and imposed upon him [sic] by his [sic] culture, his [sic] society, and his [sic] social group.
--Michael Foucault, 1988

Introduction

The research question guiding this study explores change in the lived experience of the substance abuser whose life is moving from dysfunctional-to-functional and investigates how communication grounds this change. How does communication appear in experience as one changes from addictive substance dysfunctionality to a balanced functionality and what communicative processes, in a setting of a therapeutic community, are constructive to such transitions? The methodology for answering this question of <u>how</u> suggests addressing the lived experience of transition. Narrative methodology best fits this research in that it allows the researcher direct access to experience. Narrative research is addressed as a theoretical perspective (Fisher, 1989; Polkinghorne, 1988) and Narrative also describes a methodology (Chase, 1995; Cronon, 1992; Fisher, 1989; Josselson, 1995, 1993; Riessman, 1993).

Bavelas (1995) suggests that we should allow our "data to find their own best fit" (p. 61), allowing for a both/and approach to logic rather than an either/or perspective. In answering the best fit question, the design for this research turns to the epistemology of Constructionism (Crotty, 1998) and the theoretical standpoint of the social construction of reality to understand communication in

the lived process of transition from addictive behavior found embedded in what is labeled the therapeutic community. McLeod (1997) states, "the therapeutic encounter is no longer merely 'treatment' but can be seen as a conversational and narrative event, one of many types of storytelling performance arenas available . . ." (p. 27).

Purpose of Study

Substance abuse is considered to be a whole-person disorder. The process of living in a therapeutic community evolves directly from the experiences of recovering individuals living out the changes in their lives. The research observes how change is constructed in human interaction, thus taking a Communication perspective. The purpose of this study is to understand how that communicative interaction shapes the dysfunctional-to-functional process of living.

Contextual Framework

In order to answer the question, how does positive, therapeutic communication affect change for the addictive person, a framework is used beginning from the epistemological viewpoint of Constructionism. The research design and methodology is informed by Constructionism and was explored in the context of Family Community House, a therapeutic community for substance abuse. Interviews with Family Community House administrative and clinical staff resulted in research narratives. Narrative analysis is used to determine the themes in the stories of the dysfunctional-to-functional journey for research

participants in the therapeutic community. The process this research addresses begins with the addictive individual taking the first step through the door of the therapeutic community.

Although this study began with the explicit question of how communicative interaction works to help create the journey from dysfunctional-to-functional, an implicit question emerged during the research procedure, a more fundamental concern. That is, what does it mean to be human? This question of what it means to be human is explored further and will shed light on the communication interaction within this particular research setting.

From A Narrative Perspective

Using Constructionism, Gergen & Gergen (1993) and Sarbin (1986) provide the framework for constructed narratives. Narration, "storying" experience, is one of the most basic of human communicative processes (Fisher, 1987; Polkinghorne, 1988; Riessman, 1993; Rybacki & Rybacki, 1991). When life is chaotic and disjointed, one can find the unity of one's experience in telling one's own stories. It is one's personal stories, from this perspective, that create, in the telling, the coherence that is termed "self." Since humans are storytellers by nature, it is logical that narrative theory with its "meaning-making" (Fisher, 1987; Husserl, 1936; Polkinghorne, 1988) would offer a rationality that "rings true"(Fisher, 1987) to everyday life experience. Gergen & Gergen (1993) indicate that the self-narratives, or stories, enable one to understand the action of

self and others, and in reliving one's own experience one can come to a reflexive understanding of others (p. 17).

How human beings deal with their experiential reality is through choice; each person simultaneously selects, organizes, and interprets the people, objects, events, situations, and activities upon which he or she individually focuses. People judge their own stories and other people's stories. If this common experiential process produces the "ah ha" experience in interaction that Fisher (1987), calls "ringing true," then meaning and understanding have been co-created. Since narrative is "descriptive" it offers "an account, an understanding, of any instance of human choice and action, including science" (Fisher, 1987, p. 66).

Moving from the rhetorical view of Fisher to the human science view of Polkinghorne (1988), we find Polkinghorne expands this idea further by suggesting, "the study of the realm of meaning precedes an understanding of the manner in which human beings create knowledge, and thus informs the operations of science itself" (p. 9). Research into the creation of meaning is different from research into the material realm. Polkinghorne makes this distinction when looking at research methods in the human sciences. That "the realm of meaning is best captured through the qualitative nuances of its expression in ordinary language" (p. 10) is a significant part of this distinction. Polkinghorne (1988) suggests the "activity of meaning making is not static, and thus it is not easily grasped . . ." however, "because in its ordinary use language

is able to carry meanings among people, information about other people's realms of meaning can be gathered through the messages they give about their experiences" (p. 7). He continues a discussion of how the "region of meaning must be approached through self-reflective recall or introspection" (p. 7). Polkinghorne (1988) goes on to say that "re-search implies a systematic attempt to go beyond the cursory view of something in order to generate a greater depth of understanding" (p. 10), and this, he explains, is done through narrative inquiry.

The human science view of Holstein and Gubrium (2000), Josselson and Lieblich (1993, 1995), Semins (1990), and Polkinghorne (1988) uses a narrative perspective. They present a simpler view of the narrative without the confusion or complication of Fisher's notions of narrative theory. Narrative methodology is practical in the sense that it deals with life experience and it relates to that lived experience. Narrative expression is how human beings make sense of everyday life, and narrative research explores that commonplace, mundane sense making. When something rings true to us because of our own life experiences it is much more persuasive than some abstract expression of scientific truth.

Polkinghorne (1988) states that "the realm of meaning is structured according to linguistic forms, and one of the most important forms for creating meaning in human existence is the narrative" (p.183). His perspective reflects the postmodern view that reality is constructed in interpretation through language and that stories are created from our experiences as we assign meaning to our experience. Postmodernists claim that as we converse and tell stories, we attach

meanings to our experiences, and we change our stories as we interpret our experiences and develop new meanings. Gergen (1991) refers to this reflexivity as the basis for the shift to postmodern identity. Polkinghorne (1988) and Wood (1997) suggest that we construct or produce an identity by telling stories about ourselves, and as our stories take on new interpretations, our identity can be altered. Wood (1997) defines the perception/interpretation process as "the subjective process of explaining perceptions in ways that let us make sense of them" (p. 45). When we tell stories about ourselves, we interpret experiences and assign meaning to that experience; we tell stories about others as a way to interpret, understand, or explain their behavior (Gergen & Gergen, 1993).

Looking at narrative perspective provides for interpersonal and interactional contingencies. When value is involved, the range is cultural. In communication, as cultural members, we create our shared social realities through our shared interpretive practices as enacted in any given social circumstance. Interpretive practices, in the form of common sense reasoning, accomplish both aspects of the social setting and our participation in it, as well as being that social setting (Josselson & Lieblich, 1995). "Common sense" or "good reason" is a cognition we apply individually from our place in the natural attitude. The interaction in narratives adds to behavior, an understanding of how meaning is socially constructed, thus going beyond a simplistic cause and effect perspective of behaviors.

Narrative as scientific research is an interpretative approach in the postmodern tradition, and is central to understanding how human beings construct reality. Polkinghorne (1988) uses the term narrative and its cognates, such as stories, to refer to both the process and the product. He looks within narrative for connections between events or episodes. Riessman (1993) explains this method another way: "Nature and the world do not tell stories, individuals do . . . interpretation is inevitable because narratives are representations" (p. 2). Narrative ordering makes individual events comprehensible by identifying the whole to which they contribute. The ordering of events and human actions into a whole by the use of narratives can function in research as a metaphorical window into lived experience. Because people talk about what they do and how they feel about what they do, the analysis of everyday stories can illuminate lived experience as both process and product (Gergen & Gergen, 1993; Lindlof, 1995; Wood, 1996).

Narrative data collected in qualitative interviews provides a basis for this research. The choice of Narrative Analysis is practical in the sense that it accesses life experience and makes sense of that lived experience. Narrative is how we make sense of everyday life; as a research perspective, the theory and methodology give us a scientific perspective of other human experience.

Interview Process

The primary part of the interview research in this study focuses on administrative and clinical staff surrounding the recovering participant family

member of the therapeutic community. Therefore, the privacy and confidentiality of the patient will be completely preserved. A secondary part of this research involves the clinical staff obtaining written text from two recovering participant family members. The clinicians chose individuals and gave them three agreed-upon written questions to respond to in writing, with only their age and sex included in the text.

Weber (1986) describes the research interview as "extending an invitation to conversation," suggesting that:

> Through dialogue, the interview becomes a joint reflection on a phenomenon, a deepening of experience for both the interviewer and participants . . . . through dialogue we get to think things through, discovering not only the other, but [also] ourselves. (pp. 65-66)

Kvale (1996) refers to this as "dialectic." The interview research is an on-going process between researcher and other, researcher and the data, and researcher and the self. He lists some of the components of the qualitative research interview as "life world," "meaning," "focused," "interpersonal situation," and "positive experience" (pp. 29-36). The researcher must be observant of the life-world of the interviewee and how he or she relates to that life-world. The researcher must also observe and interpret meanings as the interview progresses. During the process, he or she also has to be focused on emerging themes as well as the question of the research. The interviewer is aware that knowledge is produced in interpersonal interaction and allows for self to show in

interactional conversation, allowing for a positive therapeutic experience for the interviewee (pp. 30-31).

Kvale (1996) suggests that in qualitative research the number of interviews needed for "current" qualitative research tends to be "around 15 ± 10" (p. 102). Kvale (1996) further indicates:

> A narrative analysis of what was said leads to a new story to be told; a story developing the themes of the original interview. The analysis may also be a condensation or a reconstruction of the many tales told by the different subjects into a richer, more condensed and coherent story than the scattered stories of the separate interviewees. (p. 199)

This technique is integrated into the analysis.

Kvale (1996) emphasizes the position that qualitative research methods must meet equivalent criteria to quantitative research methods. He posits that science is "the methodological production of new, systematic knowledge" (p. 285). Kvale further states:

> Rather than dismissing commonsense understanding as unscientific, the conversations of daily life have been regarded as the context from which the more specialized scientific conversations are developed and to which they return. Systematic reflection on common sense understanding and on ordinary language conversations may contribute to a refined understanding of a human world understood as a conversational reality. (p. 285)

One acts on experience and interacts with others to create his or her reality. Making others' meaning available, through the interpretive process, results in the co-construction of that process. Using the conversational narrative approach, researchers become more involved in the investigative process. The researcher must want to understand the experience of the co-researcher. To understand the experience the researcher requires knowledge of the research topic. Kvale (1996) equates this to expertise, the continual gaining of knowledge about the research. He further indicates that "craftsmanship" in the interview process involves the researcher recognizing his or her interpretive processes and the effect on the research one is doing. In qualitative research, researchers become the research tool and cannot remove themselves from the research arena, creating situational constraints as the researcher acts as a facilitator and structural guide, accordingly being part of the co-construction of the interview and impacting the research data with his or her own fingerprints (Kavale, 1996, pp. 105-108).

Kvale (1996) compares validity in the interview process to similar concepts in social science. He lists seven stages of analysis in interview validation: thematizing, designing, interviewing, transcribing, analyzing, validating, and reporting (pp. 237-238). Validation is vital in qualitative human scientific research to assure that the research is rigorous and systematic; requiring planning and careful thought throughout. Kvale's (1996) suggestion for framing the interview

indicates that: "The interview is a stage upon which knowledge is constructed through the interaction of interviewer and interviewee roles" (p. 127).

Chase (1995) suggests "we serve our theoretical interests in general social processes when we take seriously the idea that people make sense of life experiences by narrating them" (p. 22). One needs to keep in mind that this co-construction process deals with the creation of meaning or "meaning-making." Josselson (1995) states that personal "narrative is reshaped and rebalanced as the life course progresses" (p. 29), indicating that narrative is a process of meaning making. Consequently, as Kvale (1996) proposes:

> The purpose of the qualitative research interview has been depicted as the description and interpretation of themes in the subjects' lived world . . . . a continuum exists between description and interpretation. (p. 187)

The concept of therapeutic communities addresses a program intended to move the addicted person from the dysfunction of substance abuse toward a functional life. A therapeutic community focuses on communicative interaction and the restructuring of lives in the process of living. Family Community House is the research site for this study and was created by former addicts. The staff members are former addicts sharing their experiences in order to help those who have not yet made the journey to a functional process of living. One purpose of the Family Community House program is to teach addicts and those in their communicative networks the holistic process of reflexivity.

At the various levels of the therapeutic community's administration and clinical staff, narratives were constructed through open-ended, in-depth interviews cultivating a conversational tone, thus producing narrative data (Lindlof, 1995). All but one interviewee was a former substance abuser. A narrative thematic analysis was conducted with saturated listening of the audiotapes to identify *thema* that were then analyzed. Common themes and patterns that emerged in the narratives of the co-researchers ground the research analysis.

Conceptual Definitions

"Lived experience" is a term found in Human Science. Van Manen (1990) states that, "lived experience involves our immediate, pre-reflective consciousness of life" (p. 35). We are a product of our experiences as we interact with others and we come to understand the world in our historical or cultural context. The therapeutic narratives explore lived experiences. The participants experience interactions in the process of living their daily lives on the journey from dysfunctionality-to-functionality.

Therapeutic communities began conceptually as programs intended to move addicted clients from the dysfunction of substance abuse toward a functional life through human interaction.

Addiction: Webster's New World Dictionary (1994) defines addiction as a condition of being addicted to a substance, a habitual giving oneself up to or self-medicating oneself into an extreme and harmful condition (p. 15). Addiction can

be metaphorically described as smoke. The cultural axiom "where there is smoke there is fire" suggests that it is reasonable to assume there is a source of that smoke. Addiction can lead to many other dysfunctions, beginning with the addictive person's interaction with the larger societal system and filtering down to interactions within the family unit.

Success in any drug treatment program can mean many things. Daytop Village is a Therapeutic Community that has successfully treated over 75,000 lives since it began in New York. Daytop Village has an eighty-eight percent "success" rate for recovery from drug addiction (O'Brien & Henican, 1993, p. 158). Therefore, when referring to success in this study I have adopted Daytop's criteria. Those criteria encompass: 1) living a drug free life, 2) freedom from crime, and 3) positive life style, i.e., living a productive life (O'Brien & Henican, 1993).

"Process of living" is a phrase that the staff and the participant family members at the research site use often. It refers to the everyday lived experience and the process of living a successful life, as defined above. Everyday lived experience is the living out of daily interactions of self with others.

Dysfunctional-to-functional is a phrase adopted for this study rather than "illness-to-wellness" (the disease metaphor used by the staff at Family Community House) to include both the personal and social journey that the addictive person travels. Dysfunctionality is "characterized by abnormal or impaired psychosocial functioning" according to Webster's New World Dictionary

(1994, p. 424). Functional refers to "performing or [being] able to perform a function . . . intended to be useful" (p. 546). When one interacts with others there are societal expectations that encompass functionality.

Communication has many definitions. For purposes of this paper, communication will be understood as interpersonal communication. Interpersonal communication is that which takes place in the interaction between two or more people. As the title of O'Brien & Henican's (1993) book, You Can't Do It Alone, implies, communication is the most vital ingredient and the foundation of everyday existence to becoming functional, and involves inter-dependence with others rather than the co-dependent state to which many addicts are more accustomed.

CHAPTER 3: INTERVIEW DATA

The worst sin toward our fellow creatures is not to hate them but to be indifferent to them; that's the essence of inhumanity.
– George Bernard Shaw

Family Community House

This therapeutic community was established in 1974 and the name was changed in 1995 to Family Community Treatment Services, but is still referred to by the residents and staff as Family Community House.[1] Family Community House is the study site for this research. Permission of the Executive Administrator for all contacts was obtained prior to conducting this study. Because of the nature of the research, confidentiality is a priority; no real names are used in the narratives. The University of Alaska Fairbanks Institutional Review Board evaluated the proposed study to ensure ethical practices and to insure that there were no participant risks in this research. Participation in this research was entirely voluntary.

Family Community House staff is headed by a psychologist (Ph.D.) and is supported by a Deputy who has a Master's Degree in Counseling and who leads the clinical staff as the Clinical Director. The clinical staff are ethnically diverse counselors who hold a variety of advanced degrees with an average experience base in the field of fifteen years or more. All counselors are in recovery and have themselves gone through an addiction program.

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[1] A fictious name is being used in this research to protect those involved.

Family Community House is accredited by the Joint Commission on Accreditation of Healthcare Facilities and the Commission on Accreditation of Rehabilitation Facilities and is licensed by the State Division of Alcoholism and Drug Abuse. The agency that administrates Family Community House is also a member of Therapeutic Communities of America.

Over a two-month period, four extensive interviews were conducted, with two follow-up interviews, accumulating seven hours of interview tapes. Those interviewed were the Clinical Director, the Lead Counselor, and two Primary Counselors. The two follow-up interviews were with the Lead Counselor and one Primary Counselor. In addition to the six interviews, two participant family members wrote their answers, in narrative form, to three questions posed to them by their Primary Counselor (Appendix One). One resident was a thirty-six year old female and the other resident was a forty-one year old male. They both had been members of the Family Community House for at least eight months.

During this two-month period of time, I was allowed to observe public areas of the facility and also share several meals with the participant family members in their dining area, interacting with them. Always, I was accompanied by at least one member of Family Community House.

The Setting

The setting is a sprawling, multilevel, spotless residence with well cared for flowers. The mountains frame the East and the ocean frames the West in this city of over 300,000 people. The buildings stand out from the adjacent areas

because of their sparkling clean effect. The Family Community House vans sit spotless in the clean parking lot. The house is open and there are no locked doors during the day.

A resident working the front desk greets visitors walking through the front door. This area is called "Points." Visitor arrival is immediately announced on the intercom, "Strength on the Floor, to Points, regarding a visitor." Others immediately rush to greet visitors and welcome them. The house is bustling with busy activity and appears somewhat confusing and disorganized. The intercom is continually in use. A staff member requests *support* from a family member over the intercom, and immediately many feet are heard going up or coming down stairs to that staff person's office. Again, immediately, a visitor may hear "Good afternoon family, that call for *support* was answered by Billy, Ed, Annie, and Colin. Thank you Billy, Ed, Annie, and Colin." Then heard over the intercom is, "This is Albert and I am now in phase two." The participant family members in Albert's caseload can then be heard all over the house, screaming, hollering, and hip-hip hurrahing for Albert. Requests for *support* for family members' phone calls also are heard. Mixed in with all this information is the announcement that a meal is ready.

The front desk has a multi-line telephone, an intercom, a monitor that shows the outside front area, a sign in/out clip board, and a list of information that gives the status of each resident family member, clients in orientation, and staff

schedules needed for directing the flow of communication. The network is extensive.

The resident family members also literally do all the work at Family Community House. They do the house maintenance, inside and outside. Family members do the procurement of supplies, drive the vans, "support" (i.e., accompany members) outside visits, cook the meals, do the clean up, and do their own laundry. These work assignments help to keep family members busy within a structured schedule, dealing with each participant's behaviors on a twenty-four hour basis. The ongoing communicative interaction that takes place constitutes the creation of participants' reality as they learn through human interaction to become functional human beings again.

Visitors are required to go through an hour-long orientation before being allowed to visit or talk to any participant family member. One staff person and one trained family member supervise this hour. A short video explains the facility policies and what is required of a visitor. A breach of rules means no further admittance. Another short video shows a testimony being given by a former therapeutic community graduate about co-dependency and her journey from dysfunction to being a successful contributing member of society. A family member then "supports" the visitor for the entire visit after this initial orientation to the culture.

Lead Counselor Interview

The first interview began in the large office of the Lead Counselor. The office was full of materials and boxes, a make-shift storage area. The room was clean and had a large window facing the parking lot.

The Lead Counselor will be referred to as LC. She was verbally articulate in her responses and demonstrated nonverbally, through tone, rhythm, and expression, the compassion that she says is so important in her position. LC began working at Family Community House in the early 1980's and stayed for two years. She stated that:

> . . . at that time it [the agency] was designed for hard-core street addicts. It was highly structured, and an in-your-face confrontational approach. It was a wonderful structure, etc., but the tone [LC's emphasis] was different then; I would now characterize it as abusive.

At this point there was a knock at the door and LC took time to answer a family member's question about dinner. Then she continued, "but the people who run the administration and clinical part now believe that you do not take a bunch of abused people and abuse them further and call it treatment."

As LC matured as a counselor she realized she could not be a part of that approach to addiction and left the facility after two years. Several years later, when changes had been implemented, LC returned to Family Community House and has been working there for seven years. She says that the total concept of interaction with others and the support system that is now provided for each

family member is the approach with which she is most comfortable. To demonstrate how the approach works, LC described the phases of treatment that are an integral part of the therapeutic community.

There are seven phases in the residential therapeutic community of Family Community House: 1) Orientation, 2) First Phase, 3) Second Phase, 4) Third Phase, 5) Bridge Phase, 6) Re-Entry Phase, and 7) Out-Patient After Care. Each phase is designed to benefit participant family members strong behavioral modification components as well as education about addiction and the recovery process. There is also a work therapy component and a structured component to identify and do extensive work on core issues such as training in conflict management, life skills, and refusal skills. Participants also have staff support for exploring vocational and educational options through counseling. Each family member works on an individualized treatment plan, which must meet approval by the treatment team in each phase after orientation.

The length of these phases varies with the individual but they "average three months, except orientation, which can be as short as two weeks or as long as two months," according to LC. She metaphorically relates the phases to a feast. If they breeze through on bread and water they go hungry. The "feast" begins immediately upon admission, and it is not common for clients to arrive "treatment ready" and "motivated," for they are usually placed at Family Community House for other reasons. Describing the typical client, she stated that:

> Usually sixty percent are from the criminal system, sixty percent are cocaine addicted, and sixty percent have been diagnosed with mild to moderate personality disorders. The straightforward alcoholic is rare; most are considered polydrug dependent and exhibit more than one of the above problems. We do not get a lot of heroin addicts, but we usually have a couple. Most have done jail time and have had subsequent unsuccessful treatment. They range in age from seventeen to sixty-five. The typical resident is male and in his middle to late twenties.

When I first began my research study at Family Community House, there were five women and thirty men; two months later there were eleven women and twenty-four men. The facility has a bed count of thirty-five, with seventeen more being readied for further expansion. As is the norm in the rest of the United States, clients have varied backgrounds, urban and rural, coastal and interior. The socioeconomic representation also varies widely. LC indicated that they had done a lot of work to increase the female and indigenousness population and also to increase the length of the treatment program.

At this point in the interview a knock at the door summoned us to dinner. Since I was a guest, I was introduced to everyone and was the first to be served. Most family members took a few moments to approach me and say "welcome," "enjoy the dinner; we made it ourselves," "may I help you?" or "it is so nice to have you visit us." Right after the resident family member in charge of the dining room that day said the blessing over the meal, everyone present stood and

recited a pledge that addresses the self-isolation of addiction and the need for "being alive to my self and to others." (See Appendix Two)

Since the pledge was posted on the wall, I was able to join in with family members, staff, other guests, and new clients or candidates in orientation. The new candidate graduates into the family upon completion of orientation. A family member told me "the pledge illustrates the communication ritual of verbally addressing the need for connectedness" practiced in Family Community House. Each resident candidate memorizes this pledge in orientation. Richard Beauvais wrote the pledge in 1965, while he was a resident in the original Daytop Therapeutic Community, and it has been recited in therapeutic communities since that time (O'Brien & Henican, 1993, pp. 99-100).

During dinner the members described their system of taking care of their "home" after I commented on how the house was neat and spotless. The interactions between the staff and family members and also between family members and their peers (fellow family members) are a forum to promote connectedness with others in the process of communication in family life. There were two new recruits who had entered Family Community House that day, at our table, and it was explained to them by a table mate in the second phase of therapy that:

> You need to learn the language and also learn how to function in our group. You will never be alone; there will be two of us with you at all times -- we are here to support you. We have been through orientation and it is

> not easy. We have rules that will help you to be structured, so you can concentrate on <u>your</u> journey. But at first the rules will take your mind off your problems and help you get to know us as your family. We are all glad that you are here with us.

These two new candidates appeared dazed and overwhelmed, eating and listening with caution.

After dinner the interview with LC continued. She began with a discussion about the history of this particular therapeutic community. It has been only in the past four years that Family Community House has gotten recognition from the more mainstream modalities for addiction treatment. LC clarified a mainstream modality as "for profit" and involving the medical model, and suggested that the "basic premise is social learning" for the therapeutic community. However, she added, "We are very eclectic in our approach, but the core issue we deal with is the social interaction." She explained:

> In the first phase, it is their [family member] job to become skilled – not just familiar with – or exposed to – but skilled at using the house tools and to function in this environment of a family with others. Their job is also to begin work therapy, which is a component of our treatment.

During the first phase of treatment in this residential therapeutic community, a complete medical and psychiatric work-up is required. Once medical problems are ruled out, LC said, "it's a matter of learning through interaction." To demonstrate this interaction LC says:

> The family member goes to people [peers within the house and the staff] with their problems and their treatment plan. You have a caseload group and you demonstrate with verbal input and feedback with your peers [other family members]. Another area for input and feedback is the large group, which is the group that all the members have once a week.

LC indicated that a third area of input and feedback is an "informal small group where one talks and asks for feedback" from others who have had similar problems. She says an example is, "Here is what I did; what are you doing? And is it working? What are you thinking about and how does it feel?" The context of small groups encourages working with one's family members.

Another important factor is relating to others, LC explains:

> We get people who may be forty-five years old in age, but in regards to their being able to interact with others, they are angry little nine year olds. We also find people compartmentalize [their interpersonal] skills. They cannot translate to personal relationships; it is a life skill that needs to be re-learned. A specific goal, from the minute a client walks in the door, is the need to become self-starting in the self-actualization process, and I settle for an increasing self worth . . . their process has to change . . . personally I believe in process and I am in recovery also. We are involved with each one's process as we are a family in this residential center. The clients know more about me and there is a higher degree of exposure and

> it is a self-disclosure thing because of the setting. Relating to each other is equated with connectedness.

The relationship that the family member has with the staff is an important therapeutic tool, and the staff members also view the peer relationships between the family members as the context to re-learn how to interact with others. All family members are learning this process of relating and are able to call one another on the co-dependent interactions to which they are accustomed. LC says that:

> Another way of describing recovery is: it's about relating, relating to yourself; it's about relating to other people, how you relate to substances, to objects; it's about how you relate to your higher power also. It is about connectedness . . . . isolation is usually a big part of addiction . . .

LC says that one of the things that family members have to deal with at Family Community House is "the paradox that all human beings, as they go through a self awareness process, come up against." That paradox is seen in the cultural axioms "no man is an island" and "we are born alone and we die alone." These perspectives are often discussed in the peer groups, according to LC. She adds that the chemically dependent person "usually does not know what friends are because of their trust issues" in the interaction with people in their lives. Also, if one asks the new candidate "how do you feel" they are "unable to express what they feel." He or she has to learn to express how they are feeling in order to "learn to interact in a positive manner with their peers, which is a big step in their

recovery process," according to LC. The Lead Counselor suggested making a copy of the pledge that we had recited at the dinner table. She added:

> There are different styles of working with family members among my staff counselors, but we know the feelings of aloneness and isolation, because we have all been through recovery ourselves. We recite the pledge, to keep all of us, staff and family member, aware of what we are working toward.

At this point in the interview LC used the intercom, saying "Good evening, family and candidates, Billy please contact LC in her office." Four seconds later there was a knock on the door and Billy entered upon the word "enter." LC said, "Thank you, Billy, would you take my Buddy for a walk?" She was referring to her dog that had been a quiet bystander during the interview. LC took a moment to demonstrate how to use the dog leash and Billy took her dog out the door. Again LC used the intercom saying, "Good evening family, that call for Billy was answered by Billy." The staff models politeness and respect and LC said it is a part of "being aware of the process." She refers to this "process" as the communicative process and learning to live in interaction with others. Being polite is viewed as a beginning in this social construction process with others.

As the researcher, I was interested in her continued use of the word *process*. It was determined that the interview would end and *process* would be discussed in a follow-up interview since LC was being summoned to a group therapy that was to begin shortly.

Primary Counselor Interview #1

Cora is a primary counselor at Family Community House. She has a very neatly arranged office with a small window. Cora's office is next to the visitor waiting room and near the reception area called *Points*, so it is very noisy. Despite the noise, the atmosphere is relaxing and the interview began with the history of Family Community House.

Cora has been a primary counselor for over a year, but has been involved in the facility since 1987. She said, "I have always wanted to work here." As a primary counselor, Cora, herself, is in "recovery." She says " I have always been a giver, but in the wrong way. So now I give the right way and they listen." She is on the State Board for Chemical Counselors. Cora talks about the "level of return," and how "I love and give of myself," demonstrating the importance of what interaction with others can produce. She tells about Billy, a client who ten months before had came in off the streets:

> . . . that client is still here. He was really, really sick and is now in [the] bridge [phase that transitions going out into the community] and ready to go to college. Billy could not see how he needed to change; he had always been like he was. Now he sees. Now he talks about gratitude and no longer blames others for how it was for him. He found people who did understand his isolation and we loved him; we understood him; we interacted with him and we listened to him. And he learned to talk it and then walk it.

It refers to the process of living, the communicative interaction with other family members and staff, learning to change through those interactions that at first dealt with behaviors and feelings. Willingness to change, Cora says, "helps the family members to talk to me. My female and male clients will tell me everything, when they have never disclosed before, because they are learning to trust again." Most newcomers have been to other treatment centers, but they soon realize that the therapeutic community is different. The setting of the therapeutic community requires communication through trust and self-disclosure, which is "mirrored" in the pledge that was discussed earlier. (Appendix Two) Communication is also an integral part of the daily interaction of living together in a family. Cora says she asks them:

> 'how can I help you?' instead of telling them what to do . . . . then they go and are quiet and do some processing . . . . then comes the interaction with those around them and they learn to share and interact and trust again.

In discussing a sense of pride that the family members gain as they interact more and more with others, Cora explains the environment that has been established and is conducive to change. When a participant family member is placed in a position over others he or she has a colored pen hanging from a cord around the neck to designate position, status, and authority. The holder of the white pen is a family member in phase II or higher. That person is the Senior Coordinator and runs the operations of the house. There are red pens for each

of the following departments: 1) Maintenance, 2) New Candidates, 3) Kitchen, 4) Procurement, 5) Driver, and 6) Roving Coordinator. These positions are held by a family member in phase I or higher. Each pen is held for ninety days and taken very seriously. The blue pen is assigned to the Department Head of the Candidate room. The red, white, and blue pen is assigned to *Strength on the Floor*. This position is used during leisure time, especially on weekend visiting hours. The holder of this red, white, and blue pen takes over when one of the holders of a red pen has visitors or is unable to fulfill the position of Coordinator of his or her department. The Roving Coordinator is directly under the Senior Coordinator and literally roves the house, making sure duties and responsibilities for the different departments are done and also confronting the negative behaviors of participant family members. Negative behaviors vary ranging from not doing what is suggested or required, to talking with disrespect to any family member.

The rules for behavior and interaction with others are learned in the orientation phase of treatment. Cora described how clients come in the door not knowing how to help themselves to be functional in society. She says, "they have no self respect or respect for others." Authority issues arise as treatment begins. After learning the "rules of interaction from those in authority over you, they then have the chance to be in authority over others." Cora continues to discuss change by saying "it comes hard for all of us, but we learn by our

mistakes here." Cora explains what is said to all newcomers and emphasized throughout treatment:

> We let the family members know they run the house and they are responsible for what goes on here. Everyone has a job function. The staff is here to give counseling and give treatment services, and to incorporate change. The family member learns how to communicate and also learns social interactive skills. They make it work through their communication with others and their treatment peers.

Cora gives an example of how this communicative interaction works. The community does not come to you, but rather the resident lets the other family members know "these are my issues and I need some help." She continues, "Family Community House uses "experienced based therapy." You are in the experience, you get to live it, feel it, speak it, and understand it, you are here in the experience." Cora says the family member is encouraged to:

> Let us know 'how it is going for you and we'll help if you want.' The family members are not dictated to or programmed. Rather, they learn a sense of pride, learning to accept and have respect for themselves through their interactions with other family members and staff and eventually with their families and their community.

Primary Counselor Interview #2

Paul's office is next to Cora's, however, it is much smaller. It is dark outside and only a 60-watt light bulb lights the room. The atmosphere is pleasant

and relaxed with Native American décor. A Spirit World poster is on the back of the door. Paul's voice and manner of speaking is soft, concerned, and contributes to a comfortable and relaxed interpersonal atmosphere.

Paul described his own recovery, saying that he has been a primary counselor at Family Community House for three and a half years. He says that he was a professional cook by trade and that "I went through seven treatment centers" before finally graduating from a therapeutic community. The therapeutic communities are different, he says:

> We deal with behavior twenty-four hours a day. The family member does all the work assignments in the house. The leadership is all in the client structure. They drive the vans . . . yes, they go with support. There is no such thing as snitching; they learn the difference between snitching, confronting, and reporting negative behavior, which is part of our program.

Negative behaviors are outlined in the Thinking Errors Workbook, and family members work on their thinking errors that have produced interpersonal disasters in their lives (See Appendix One for a copy of some of the errors worked). An example of this process is that of a learning goal to understand that events "don't just happen." Residents are asked, "How did you get to this situation?" They are asked to plan a future, being reminded they can create that future through their interaction with others and remembering that one thing leads to another. Once they have decided what they want for the future, they are assigned to list steps that they need to take to reach their goal. If the goal is to go back to their family,

for example, and be a responsible mother or father to their children, then they talk about the irresponsible choices they have made, what a responsible choice would be, and what choice they could have made.

Another example from the Thinking Errors Workbook is sound decision-making skills. Working through the workbook is done individually and in small groups. Paul says, "everyone in this treatment center has lost everything they got; honesty, values, jobs, everything, but one thing, and that is human dignity . . . we need to help them build that back up." Combining old World traditional wisdom with the new literate culture, Paul tells the family members, "I had no priorities in my day in my last treatment." They are then asked what their priorities are – "something to establish self." Paul says, "I tell them Recovery and God are number one, Self is number two, and Others and Situations are number three."

Reality interaction between peers is described by Paul as a daily positive process. When asked how he can be so positive when he has gone through so much personal anguish, Paul replied, "Well, I use stories, my culture uses stories to teach and I like to use those stories." One of the stories that he uses is:

> There are two fighting dogs, a white pit bull and a black pit bull. And they are going to fight in about four weeks. The black pit bull, I am going to feed it, exercise it, and give it water . . . and not even bother with the white one. I know the black one will win, so I bet on him . . . to make lots of money. I feed and take care of the black one so he kills the white one in

> no time at all. Inside of you and me are two fighting dogs. The white one is positive and the black one is negative. Which one are we going to feed today? Not tomorrow, just right now.

Paul says, he "chooses to feed the positive one today," saying: "they need role models, something to be proud of." He says he tells family members:

> You cannot kick people to the curb and let them go. I am like each of you. I am the helper and you are the boss of this journey we are on together. We are warriors. If I see danger, I will tell you, but it is your problem, not mine.

Family members are told repeatedly that it is up to them, Paul says, "You need a plan and goal for yourself. You need to do your own goals, not my goals, but do it in a positive way." In relating an incident from the day before, Paul tells about a family member who was crying at meal time, making everyone nervous, and no one knew what to do to help this person. He says, "I went up to him and said 'hold it! What is bothering you?'" The man said "I'm thinking about how I got beat up, physically, mentally and sexually abused and that stuff." Paul said:

> Well the hell with that, don't think like that, chop it off, now. Think about a good time when you were a child, when you were in a safe place and you had lots of fun. Remember those good times; don't bring yourself down with the negative stuff, I am sick of it. I am sick of you thinking like that. You bother me when you try to take me back with you, forget it, I am not going back with you. Let's look at the good stuff.

Paul suggests this story illustrates the mindset, "it is up to them, this interactive journey we are on together." He says the crying man was isolating himself with his inner world of shame and pain. That self-imposed isolation is why participant family members are always kept busy and have a schedule to follow. Paul says, "we are not in the business of teaching the family members how *not to do drugs*, but rather we are teaching them how *to live again*." They are co-creating a different and more productive reality together. Referring back to the pledge, Paul says again "we acknowledge our isolation and reach for change and self respect."

A knock on the door and Paul was told a family member "blew up in process, and is packing." I was asked to turn off the tape, and the interview abruptly ended.

Lead Counselor Follow-up Interview

This interview was the second interview with LC about four weeks later. The discussion centered on *process.* Each family member is encouraged to live in the *now* of the process, referred to as *present in the process*. LC indicated "being aware of the process is a powerful thing for family members as they are consciously living it on an hourly basis." Participant family members learn how to focus on being in the moment, "one day is too long for most of them," such as the man who was crying about his past and needed help to climb out of his isolation. The person in recovery needs to go from event to event, *being in the here and now*.

A family member is *directed* by staff or members with a pen or *suggested* by other family members to the "bench" when their attitudes and/or behaviors do not follow Family Community House Protocol. I was not allowed to see a member "run a process" but LC explained how the process for an event consists of the attitude or behavior that was amiss and how that relates to past, present, or future, and also the solutions on how to present self in the future. She explained that the offending member faces a mirror, and verbally describes, "What did I do wrong and how and why has it affected others?" The offender will then be given a "consequence" by his or her *support* person, freed "up," and then may return to whatever he or she was doing. A consequence could be re-cleaning a clean closet, by taking everything out of it and scrubbing the closet and putting everything back. Or it can mean extra kitchen duty or even four hours of silence. This is called *running a process*.

Another component is called *clean process*. LC explained, "this is the key to recovery." The clean process focuses on questions of "how to go about meeting self wants and needs and following the golden rule in interaction with others." Paul described it another way. He referred to clean process as "a *good orderly direction."* Good orderly direction is remembering that "there is a feast before you" and that if you "eat bread and water" you have chosen to slip into a *dirty process*, which is cutting corners, that which LC said, "often leads back to addiction." She indicated that this "*clean process* and *good orderly direction*

involves living in the moment, the now, and taking responsibility for your interactions with others."

Family members go through an evaluation process. When they learn how to be aware of their individual process of living in awareness, they have also learned through the communication process how to verbalize the change that is taking place. Feedback is instant with so much family around. For instance, if one cuts corners in a job, or makes a flippant remark to someone in response to a request, he or she is "directed or suggested to run a process" as described above. LC indicated that for the more difficult problems, a *learning experience* is needed to address difficult issues for an individual, such as continual cursing or silence. A written, specialized behavioral contract is drawn up with the primary counselor, a panel of peers, and the individual. The clinical staff and treatment teams have approval responsibilities over these learning experiences.

Clients enter Family Community House through self-referrals, the criminal justice system, referrals from others agencies, and other treatment programs. Throughout its history, Family Community House has provided a "long-term residential treatment program for profoundly addicted substance abusers," LC said. Originally there were three separate racial groups, one for Native Americans, one for African Americans, and one for Caucasians. With these divisions enforced by separate group action and support interaction, diversity problems arose. *Experience Based Therapy*, LC said, is the combining of these three groups into one multicultural group.

At Family Community House, three different cultural activities are held each month now. The day I conducted two of the interviews, the whole family had participated in an Experienced Based Therapy and completed a performance put on for the public to show the benefits of diversity. The group had shared songs, skits, and "talks on how we are learning to work together to become a giving part of the outside community," as Paul indicated when he said, "their performance was fantastic." He said "we learn about each other's culture by sharing our experiences . . . by learning to appreciate the food, music, language, and art of their various cultural and ethnic backgrounds."

Family Members' Interviews

The next two interviews were written responses by two participant family members in response to three questions asked of them. One resident family member was a thirty-six year old female and the other resident was a forty-one year old male.

Candidates are required to complete a formal orientation process, which takes from two weeks to two months. During that time he or she is not allowed to leave the premises without three phases of *support* with them at all times. Upon entering Points, the candidate is assigned a big brother or sister who helps him or her adjust. At this time they are usually what they call *dirty*; a term used for not clean of substances. A resident describes his first entry into Family Community House:

> The first minute I came in, the person at the front desk made an announcement 'good afternoon family, we have a visitor at Points, Strength on the Floor to Points.' Within thirty seconds there was a rush of people all around me at the entrance. I was confused, overwhelmed, and in shock.

Another resident describes her first moments in this same environment:

> . . . being overwhelmed with fear. Fear of what was expected of me and fear of what would happen to me if I did not meet everyone's expectations, including my own. Then everyone in the house started telling me who they were and why they were here and I knew I was in a house full of people just like me and I had hope for me.

After this initial contact with other family members the process of interaction with others began. One family members said:

> It was hard for me to interact with others. I have an extensive criminal history, and I had taught myself to be tough to survive, so it took awhile for me to trust others around me, to share about me, and I still have a way to go, but I am getting better.

Another family member said, "My interaction was submissive, cautious, and limited to following directions and instructions to get my needs met." He writes about being off-balance saying, "becoming O.K. [sic] with myself means to be open, honest, and willing to change my behaviors which produce negative affects [sic] in my life." After eight months, the family member said "I feel confident to

make appropriate choices today and know/feel I am not *alone*." A female family member found it a difficult journey, taking twenty-six months to be able to say, "It makes me feel human, which is a whole new world after the last ten years . . . I feel good!" Being able to express him or her self is one result of the eight months spent at Family Community House, according to the Clinical Director.

Clinical Director Interview

The last interview was conducted in another building across the street from Family Community House in the administrative offices. The office was busy; everyone was working on a new project that was about to be implemented. The Clinical Director's office was large and comfortable. The Clinical Director, James, has a low, calm manner of speaking, and appears to be able to handle his responsibilities quietly and without panic.

James immediately took control of the interview after saying "hello, and welcome," with:

> I have read your proposal, you are attempting to come from a new perspective and this is always helpful. I will tell you about the bigger picture, since my staff has already covered the basics of behavioral interaction.

The therapeutic community operates as a non-profit organization, thus James explained, "one of the constant variables with this type of service is the funding we have to provide." Over a long period of time one sees the political pendulum swing back and forth regarding recognition of the need for a recovery program.

The need changes from the medical model program, the outpatient program, the short-term or mid-term treatment, to the long-term residential treatment program. He said that right now "it is popular thinking to spend funds on out-patient care rather than residential care."

James continued to discuss the political aspects of the Board of Directors and their support of political candidates that fight the "war on drugs" through enforcement, and ignore the "scientific evidence that shows that enforcement does not work as a tool for recovery from addiction." He suggested that there "simply are not enough beds in prisons to hold all the substance abusers that have been sentenced," and emphasized:

> Studies show that close to eighty percent of those incarcerated and confined for misdemeanors and felonies in our institutions are chemically dependent or chemically abusive in this State . . . . both categories require treatment.

The new program that the staff is working on deals with the "treatment" portion of incarcerated substance abusers. Seventeen more beds are being added to Family Community House for those leaving the prison system and learning to re-enter society. The Clinical Director will be responsible for merging the functioning therapeutic community and the new re-entry program from the prison system.

After an interruption by his secretary, regarding a phone call, the Clinical Director talked about issues that the family members face each day:

> The relationship has to be based on trust and confidence, in order for the program to work. The counselors need to interpret what the client is saying, and use language to create meaning with them. Such as, if you forget to push your chair in at the dinner table when leaving, you have to put your name on the dish list and wash the pots and pans. This makes you live now in the present and to be attentive to what is going on around you.

James suggested two or three things are going on at once with each of the participant family members, for example "challenging authority, legal problems, and negative thinking." These affect every interaction of family members with their peers and primary counselor. Because of the highly structured setting, family members must deal with these problems moment-by-moment. Those around to *support* him or her have developed skills to constantly confront those dealing with the process of living in the present. James indicates:

> Once they have learned these skills they become aware of their own weaknesses, as someone is always there to confront them on any negative behavior. You are not alone, so you learn to deal with your interactions with others or you leave.

Participant family members are told to "walk your talk." This means doing for yourself what you suggest to others. A true role model makes choices to behave in ways that are consistent with the feedback they give others.

Another aspect that the administration deems important is the re-entry phase. Since the participant family member has progressed in treatment, he or she has become skilled in the various work areas or departments that they have worked such as: 1) Maintenance, 2) New Candidates, 3) Kitchen, 4) Procurement, 5) Driver, and 6) Roving Coordinator. By the time the participant family member enters the bridge phase, he or she has learned life skills in communicating with others and in various family jobs while at the therapeutic community.

For instance, one who has directed Family Community House front desk has learned skills that are used when he or she re-enters society seeking employment. Those skills include intercom use, multi-line telephone skills, decision-making skills for directing visitors, vendors, and thirty-five family members and staff, as well as watching the surveillance camera video. Skills learned from managing the communication flow of the whole family prepare the family member for re-entry into the "real world." James says, "learning to be responsible for yourself in each phase, before advancing to the next phase, gives the family member a mature view of responsibility" on his or her journey in the *process of living.* The process of living is socially constructed in the interactions between family members, their peers, and Family Community House staff. The doctors and staff are part of the system of support, and as one counselor in this study said, "treatment is not something done to you, rather it is done with you." Investing-in-your-own-recovery is the therapeutic approach.

CHAPTER 4 – NARRATIVE ANALYSIS

In the beginning is the relationship.
-- Martin Buber, I and Thou

Narrative and Emergent Themes

This study began with certain assumptions. One basic assumption is a Heidegger (1962) concept; a concept of what it is to be human. The data collected from Family Community House is a slice of the lived experience for those participant family members and staff members who are participating in their process of living, learning to function in society. Another assumption is seen in the literature review, the social construction of reality in our everyday interactions with others. Also, another more basic concept is stated by Lindlof (1995) "the notion that meanings are continually constructed lies at the center of interpretive approaches in communication . . ." (p. 24). The interpretive approach or epistemology of Constructionism permeates this study of the journey from dysfunctional-to-functional in a context of a therapeutic community for substance abuse. To analyze the data, these assumptions are described in the context of narrative thematic analysis.

As the researcher I selected, organized, and interpreted the data collected on a continual basis throughout the research process. As Denzin (1989) suggests this "allows interpretation to emerge from the stories that are told . . . and no single story or interpretation will fully capture" (p. 136) the whole, but rather gives one a view of a specific moment in time. When one tells his or her

our story "it allows interpretation to emerge . . . reveal[ing] the conflictual, contradictory nature of lived experience . . ." (Denzin, 1989, p.136). As Riessman (1993) suggests, when doing narrative analysis, one asks why the story is told in the manner it is and how the teller imposes order in a multitude of actions, "to claim identities and construct lives" (p. 2).

Narrative analysis discovers forms of lived experience. Narrative is well suited to studies of intersubjectivity and identity such as that of family members of Family Community House. Kvale (1996) posits:

> dialogical intersubjectivity refers to agreement through a rational discourse and reciprocal critique among those identifying and interpreting a phenomenon . . . with a dialogical conception of intersubjectivity, the interview attains a privileged position—it involves a conversation and negotiation of meaning between the interviewer and his or her subjects. (p. 65)

Story telling is a way of making sense of experience and constructing meaning in the interaction with others. Gergen (1994) says relationships "replace[s] the individual as the fundamental unit of social life" (p. 252). Intersubjectivity is the construction site for identity changes and forms the foundation for the process of living. Semin (1990) says the use of everyday language, which "generalizes over different actors and observers who occupy the same place at different times or different places at the same time" is communicated as "intersubjectivity" (p. 160).

Owen (1984) talks about the recurring of meaning and the repetition of words and/or phrases in the emergence of themes (p. 275). Narrative analysis is also discussed as an organizing principle of human behavior (Cronon, 1992; Fisher, 1987; Sarbin, 1986) in describing the emergent themes. The data is from a specific moment in time and the emerging themes in the capta collected also tell a story of *isolation*, *self-disclosure*, and *connectedness. Isolation, self-disclosure*, and *connectedness* are the three themes that emerged from the data through saturated listening and from the words of the interviewees taken from the transcription. When a breach between the ideal and real, self and society happens, people tend to translate their knowing into telling, in order to make sense of their lives. The process of telling his or her story takes the family member from isolation to self-disclosure and eventually to connectedness with peers and staff members. The sequence of actions that take family members through relational re-definition begins with telling their story, disclosing what they have lived, thus producing a connectedness to others who are also going through that process.

Isolation

We multiply distinctions, then deem that our puny boundaries are things that we perceive, and not that which we have made.
--William Wordsworth

Isolation is the first theme to emerge in the analysis and is the first issue attended as a new client walks through the doors. As seen in the client's statement "within thirty seconds there was a rush of people all around me at the

entrance" and from then on he was not left alone, but was assigned a big brother and one other family member to support him at all times. Experiences of recovering individuals living out the changes in their lives necessitate climbing out of the self-imposed isolation that the addict has forced on his or her self. The living out of change is a vital part of the journey to a functional life. Change begins for each candidate with the steps of walking through the door of Family Community House. That step is directly confronted with, "tough love, honest love, and demanding love" (O'Brien & Henican, 1993, p. 22). As Paul said, "I love them, I don't care what they have done, I love them . . . I lived it, so I know what it feels like." Therefore, staff and other family members in the beginning process immediately confront isolation as a constructed reality of the candidate.

Self-identity "is not an object which stands by itself" (Sarup, 1996, p. 16). As Gergen (1999) states, "who I am and the nature of my actions come to be negotiated and defined within relationships" (p. 82). Even our "modes of description, explanation and/or representation are derived from relationship" (p. 48). Of the new candidate LC says, "Isolation is usually a big part of [his or her] addiction." Isolation as "constructed realities are always born of a price and precariously situated" (Gergen, 1999, p. 102).

The orientation phase is a structured process that uses the Thinking Errors Workbook in guiding the new recruit through the behaviors of isolation. There are new candidates who are forty-five years old who do not know how to interact with others, "their actions are those of an angry nine year old," LC states.

They have successfully isolated themselves for various reasons and this isolation is seen in their behaviors and in their words.

As one family member says, she has a problem talking to others, because she has "taught [herself] to be tough in order to survive" not only on the streets, but also in prison. As one Primary Counselor indicated "rituals and confronting" are two tools used to help the new recruit out of self-imposed isolation in order to survive. Isolation translates into not having the interactive skills needed for a functional life process, and this becomes the reality for the addict. So the sub-theme, self-awareness, is discussed in peer group sessions as the family member works out his or her isolation.

Josselson (1995) suggests that the dialogic nature of self is the dialogue within self and the dialogue with the world. By becoming aware of the interaction of these parts one can perceive the essence of the whole. Josselson (1995) describes language as "the medium in which reality is represented" (p. 36). She further posits that "Only by listening to what our participants tell us of their experiences can we enter into dialogue with their meaning system . . ." and that "this is the value of narrative forms of investigation" (pp. 36-37). Family members confront these opposing dialogues within, and learn to verbalize the feelings they produce as part of their treatment in various therapy sessions. These sessions include one-on-one with a Primary Counselor, small group sessions, and whole family group therapy sessions.

Gergen (1999) posits Social Constructionism "invites a continuous posture of self-reflection" such as "some might even be moved to withdraw from all discursive commitments . . . only to find that withdrawal itself is but another form of commitment" (p. 221). He describes it another way, by saying, "each commitment to the real eliminates a rich sea of alternatives, and by quieting alternative discourses we limit possibilities of action" (p. 223). For the new candidate his or her commitment to isolation has various reasons or "thinking errors" behind that commitment. (See appendix three)

The "new candidate is never left alone," says LC, but is "accompanied by a big brother or big sister or another family member at all times." The individual is confronted with their "thinking errors" and works the workbook through interaction with the family on a continual basis. As the therapeutic pledge says, "I am here because there is no refuge, finally, from myself, until I confront myself in the eyes and hearts of others . . ." An example of re-learning or re-definition is to confront self instead of isolating one's self, this is experienced in "running a process." In "running a process," he or she verbally describes, "What did I do wrong and how and why has it affected others?" as LC explains.

Self-Disclosure

The point is not a set of answers, but making possible a different practice.
--Susanne Kappeler

Self-disclosure is the second major theme to emerge in the data. Gergen & Gergen (1993) show how individuals use narratives through reflexivity to reconstruct a sense of self. These self-narratives help the substance abuser to

make sense of his or her world. The therapeutic community is embedded in what the Clinical Director, James, calls a "social milieu and this milieu relies on a rehabilitative method that the scientist refers to as social learning." Within this milieu relationships have to be based on trust and confidence in order for the program to work. James explains that the "counselor needs to interpret what the client is saying and use language to create meaning with them." Self-disclosure begins the process of living, and meaning making is a step or sub-theme in that disclosure. Stewart & Logan (1993) indicate that "presenting your personal self requires trust, and it also creates trust [consequently] . . . disclosure begets disclosure" (p. 245). One of the benefits of personal disclosure is that it gives information about you to others and this also contributes to relationship development. Self-disclosure also clarifies opinions or ideas, and of benefit to all is the catharsis it provides in regard to the isolation in which an addict has placed him or her self (Stewart & Logan, 1993, pp. 243-244).

Since each of the counselors at Family Community House is a recovering addict, Cora says the "counselors share themselves and their stories with the family members, establishing trust." In turn, as trust is developed, the self-disclosure is demonstrated. For example, in the words of one family member: "everyone in the house started telling me who they were and why they were here and I knew I was in a house full of people just like me and I had hope for me." LC, the Lead Counselor says, "we learn about each other by sharing our experiences."

Relating emerged as a sub-theme of self-disclosure. LC says that at first the candidate "cannot translate to personal relationships" the skills that he or she has learned through their interactions in the substance abuse culture, and as a consequence life skills need to be re-learned. The lead counselor suggessts, "another way of describing recovery is . . . relating; relating to yourself; it's about relating to other people, how you relate to substances, [and] to objects." Relating is constituted in our interactions with others. So a structured environment for re-teaching the life skills of reflexivity and relating are built into the daily operation of Family Community House.

One creates certain metaphors to explain or justify his or her actions and thus creates "texts of identity" according to Harré (1989b), such as the "family" or "feast" metaphors that are used at Family Community House. Family and feast become the contexts of the therapeutic community. Self-disclosure within the family is for therapeutic value and allows one to "eat a feast" instead of only "bread and water" as LC declares. One learns about his or her self as he or she begins to disclose the self, not only in the actions of everyday living in a family, but also in language when running a process, in peer groups, and in family group sessions.

Shotter (1991) suggests one not only learns about the other but "re-authors" the self (p. 105). According to Gergen (1999) "we transform our understanding of selves through language" and this gives "new meaning and dimension to our lives . . ." (p. 117). One uses "the story form to identify

ourselves to others and to ourselves" (Gergen, 1994, p. 186). At Family Community House self-disclosure can produce issues that must be dealt with on a daily basis. For example self-disclosure means a higher degree of vulnerability for the candidate. Being honest with self and other is part of the structure.

Connectedness

The whole dear notion of one's own Self – marvelous old free-willed, free-enterprising, autonomous, independent, isolated island of the Self – is a myth.
--Lewis Thomas

Connectedness is the third theme to emerge in the data. Connectedness is an attitude of living in the now and this awareness is a process that comes with behavioral changes. Gergen (1999) says, "with multiplicity comes flexibility" (p. 239). Anderson & Ross (1994) indicate if we want to define communication realistically we find that the root of all purposeful communication is the notion of commonality. The process of living is exemplified in their statement "shared meaning is not the property of individuals, but rather pooled between them in the middle . . ." linking two separate people, which "becomes their communication" (p. 63). Consequently when describing connectedness that emerges in the data, the analysis will include the sub-theme of relating shared meaning as part of the major theme--connectedness.

The family member, through communicative interaction with others, learns respect for self and other. They learn responsibility through their assigned family jobs. And, they learn to incorporate change through the process of living life on its terms, learning that it is all right to make mistakes but that there are

consequences. These consequences emerge when the family member is "running a process." Family peers help each other in this therapeutic context. The mirror effect is used to learn appropriate behavior. Family members also keep daily journals of their progress in the process of living. This "visual record shows their growth" and is "reinforcement" in the down times of that growth, according to LC. As Paul stated "we are not in the business of teaching . . . how not to do drugs, but rather we are teaching . . . how to live again" in the communicative "interaction with others." As the Lead Counselor says "we recite the pledge, to keep all of us, staff and family member, aware of what we are working toward." Learning "how to live again" in "interaction with others is not easy" and is a continual process--a process of living that results in connectedness.

The context of the therapeutic community allows for reflexivity during the running of a process. And using his or her everyday personal experience as a starting point for change allows instant feedback. The self-imposed isolation that candidates have experienced changes as they begin to experience a different state. Steier (1995) says "by becoming aware of our awareness . . . reflexivity becomes . . . a social process, allowing more space for others" (p.83). As the family members progress through the phases, they begin using the stories of self in helping others who are new to the process, as seen in the various "jobs" in Maintenance, New Candidates, Kitchen, Procurement, Driver, and Roving Coordinator positions as well as in peer group sessions.

The family member is re-inventing self on the journey to becoming a functional part of society. As McLeod (1997) reveals, the client tests "a range of experiments in living, some of which are unsuccessful and others more productive . . . the sense is of a person who is actively trying out alternative life-stories in order to find the one that fits, that can be lived in, that can form the basis for a satisfying life" (p. 131). They are learning to be re-connected to others in a meaningful interactive process. That connectedness is ". . . not alone anymore, as in death, but alive, to my self and to others" as the last two lines of The Family Community House Pledge state.

Summary

As demonstrated in the data collected in this research, the skills of a process of living are tools used continually for the substance abuser on his or her journey to functionality. The emergent themes from interviews in this study were isolation, self-disclosure, and connectedness.

Isolation is self-imposed for survival, so self-disclosure is a difficult process for the substance abuser. The substance abuser is in a nightmare surrounded or "overwhelmed with fear" and "not wanting to trust others," as one addict expressed because of her previous experience on the streets and in prison. The process of communicative interaction is a vital step as demonstrated in all three emergent themes.

The counselors operate from lived-experience and training from the discipline of psychology. Terms and phrases like *support, strength on the floor,*

family, present in the process, clean process, learning experience, *bridging,* and *good orderly direction* indicate the dedication of the administration of Family Community House to the process of living on the journey from dysfunctional-to-functional for the substance abuser. In order to cross this gap one has to create a metaphorical bridge. According to Gergen (1999):

> . . . different meaning generates a bridge to another community, to other conversations, and to still other meanings . . . in effect, the profound malleability of words works to destroy firm boundaries, and lends itself toward broadening the range of participants in the conversation." (p. 236)

Gergen's (1999) assessment of interpretative analysis is:

> We gain most if we appreciate these analyses not as reports on objective truth, but as "frames" or "lenses" on our world – to shake us up, reconstruct, give further dimension, and open new vistas of action. There is always more to say – for which we should be thankful. (p. 86)

This research provides a snapshot into the bridging that takes place in a therapeutic community. The bridging for those addicted to substances as they travel on the journey that shapes the dysfunctional-to-functional process of living shows us how change is constructed in communicative human interaction.

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Appendix A

Interview Protocol:

Q1: Tell me about the history of Family Community House as an organization. Please tell me about your history with Family Community House.

Q2: Therapeutic Community is an interesting term. Could you tell me your concept of Therapeutic Communities and their origins?

Q3: Tell me how you view the current impact of Family Community House on the residents, the impact on the residents' families, the impact on your city, and the broader impact on the State.

Q4: What are your goals for the residents' journey from illness toward wellness?

The three questions asked of the two participant family members were:

Q5: What was it like for you the minute you came through the door of Family Community House for the first time?

Q6: Describe your interaction with others. (Implied both staff and other residents.)

Q7: Describe your journey from "illness to wellness." Describe how it <u>feels to you</u>?

Appendix B

Family Community House Pledge

Pledge by Richard Beauvais, 1965

I am here because there is no refuge,

Finally, from myself,

Until I confront myself in the eyes

And hearts of others, I am running.

Until I suffer them to share my secrets,

I have no safety from them.

Afraid to be known, I can know neither myself

Nor any others; I will be alone.

Where else but on this common ground,

Can I find such a mirror?

Here, together, I can at last appear

Clearly to myself,

Not as the giant of my dreams,

Not the dwarf of my fears,

But as a person, part of a whole,

With my share in its purpose.

In this ground, I can take root and grow.

Not alone anymore, as in death,

But alive, to my self and to others.

Appendix C

Thinking Errors Workbook[i]

ERROR	GOAL
Sexuality	Changing sexual patterns, gaining respect for your partner.
"I can't" attitude	No more "I can't."
Not achieving a time perspective	Understand that events "Don't just happen."
Failure to consider injury to others	Sensitiveness to hurting others.
Failure to assume responsible initiatives	Start something responsible and stick with it.
Fear as a guide to responsible living (fear of fear)	Fear can be a friend.
Lack of interest in responsible performance	Instill an interest in responsible living.
Poor decision making for responsible living	Sound decision making skills.
Concrete thinking	Learn to think conceptually and see the big picture.
Uniqueness	Keep uniqueness in perspective, "I'm just ordinary people."
Suggestibility	Staying away from irresponsible people and situations.
Energy	Redistribution of energy - Don't waste time.
Anger	Reduction of anger - "I can choose not to be angry."
The power thrust - power and control	Let other people breathe.

[i] This is a summary of the Thinking Errors Workbook used by the family members

Appendix D

Graduate Research Informed Consent Form

Clinical and Administrative Directors,

Ethical guidelines of privacy, informed consent, confidentiality, protection from harm, sharing results, debriefing, sharing benefits, and ensuring high ethical standards will be strictly followed in this research. Names will not be used in any report or paper. A pseudonym will be used for the narrative stories from the interviews. Strict guidelines for participant confidentiality and impartiality will be adhered to as well as respect for all persons regardless of gender, age, race, ethnicity, or sexual orientation. Participation in the study is completely voluntary at all times.

The research project will gather narrative data for a graduate thesis exploring how communication appears in experience as one changes from addictive substance dysfunctionality to a balanced functionality and what communicative processes, in a setting of a therapeutic community, are constructive to such transitions?

Individual open-ended, informal, and absolutely voluntary interviews will be conducted. Those interviewed will be the Administrative Director, Clinical Director, the Lead Counselor, and two Primary Counselors. Also follow-up interviews of the Lead Counselor and a Primary Counselor would help clarify any arising questions.

Prior to beginning the interviews I will discuss my communication research with the interviewees. You will be asked to spend approximately a half-hour to an hour of your time. The interviews will be tape-recorded for transcription and qualitative analysis. The audiotape will be destroyed directly following the transcription process. There are minimal risks involved in the research process to participants or researcher, but if any should arise in the process of analysis, you will be promptly notified.

As agreed, you will have the opportunity to read the research product before it is finalized and have an opportunity to emend and approve the contents. Since this research addresses process you will be provided with a copy for your files, as requested, for the benefit of accessing the process now in use.

By reading and signing this form, you both agree to allow participation of your selves and your staff in this research.

Thank you for your interest and participation in this communication research project of your Therapeutic Community facility. If you have any further questions please contact me at my office:

Graduate researcher: Victoria J. Cramer
Office telephone: (907) 474-1876
Email: ftvc@uaf.edu
Office: Rm. 401, Fine Arts Bldg., University of Alaska Fairbanks, Department of Communication

Administrative Director Clinical Director

Sincerely,

Victoria J. Cramer
Department of Communication
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